

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024587

3496

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED JUL 5 1963

VS 300
Rev. 4/59

1

2 3478

3

4 1

5 2

6

7 1

8 2

9 4500F

10

11 123

12 68-0

13

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Missouri Length of stay in 1b 60 yrs | | c. CITY OR TOWN Kansas City, Missouri Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 300 W Armour Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Edith Middle Irene Last Scott | | 4. DATE OF DEATH Month 6 Day 21 Year 63 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-19-75 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Telephone Co. | 11. BIRTHPLACE (City and state or country) Iowa |
| 13a. FATHER'S NAME George T. Chadwell | | 13b. MOTHER'S MAIDEN NAME Mary Jane Henry | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No | | 17. INFORMANT Address Neb. | |
| 18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Thromboembolism Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) fracture of femur | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Intertrichonitria | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED, Enter nature of injury in PART I or PART II of item 18.) Fell in house | |
| 20c. TIME OF INJURY Hour 5:00 a.m. Month, Day, Year May 18-63 | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 20f. CITY, TOWN, OR LOCATION Kansas City COUNTY Jackson STATE Miss | |
| 21. I attended the deceased from May-18-63 to June 21-63 and last saw her alive on June 21-63 Death occurred at 10:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Carl A. Brust M.D. | | 22b. ADDRESS 106 W 14th Kansas City Mo | |
| 22c. DATE SIGNED 6/21/63 | | 22d. LOCATION (City, town, or county) (State) Omaha, Nebraska | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 6-22-63 | |
| 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial | | 23d. LOCATION (City, town, or county) Omaha, Nebraska | |
| 24. FUNERAL DIRECTOR Kansas City Mortuary 4316 Troost | | 25. DATE RECD. BY LOCAL REG. 6-22-63 | |
| 26. REGISTRAR'S SIGNATURE Ruth Long | | | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Forrest D. Coldenow

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.